MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • General Medicine

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Contents

MRCP Benefit Added

Effective retroactively for dates of service on or after January 1, 2005, Magnetic Resonance Cholangiopancreatography (MRCP) is a Medi-Cal benefit when billed with HCPCS Level II code S8037. MRCP procedures may, in certain situations, provide information similar to endoscopic retrograde cholangiopancreatography (ERCP), but offer some advantages.

- Iodine-based contrast is not used, avoiding allergic and osmolar risks
- Avoids ERCP with its potential attendant medical complications
- Avoids risk of sedation and/or anesthesia
- May be less costly than ERCP

Prior authorization is required for MRCP. In addition to a *Treatment Authorization Request* (TAR), providers must submit documentation of at least one of the following medical indications:

- The recipient has undergone an unsuccessful ERCP procedure and requires further evaluation.
- The recipient has altered biliary tract anatomy from prior disease or surgery that contraindicates ERCP.
- The recipient requires evaluation of a suspected congenital defect of the pancreaticobiliary tract.
- The recipient has a pancreaticobiliary medical problem suspected to present a low probability for therapeutic intervention with ERCP, but requires diagnostic work-up to direct medical management.
- The recipient has a proximal pancreaticobiliary anatomic defect that cannot be reached by ERCP, due to obstruction.
- The recipient is a young child or compromised adult where ERCP may be unsafe or cannot be performed.
- The recipient is allergic to or has a contraindication to receive iodine-based contrast media for an ERCP.

Providers may bill code S8037 with modifiers -26 (professional component), -TC (technical component) and -ZS (professional and technical component combined).

The information is reflected on manual replacement pages hcpcs ii 2 (Part 2) and radi dia 17 (Part 2).

Azacitadine is a New Benefit

Effective February 1, 2006, azacitadine 100 mg is a new Medi-Cal benefit, reimbursable with HCPCS code S0168. Azacitadine is used in treating Myelodysplatic Syndrome (MDS). HCPCS code S0168 also may be billed in conjunction with CPT-4 code 96400 (chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia).

The updated information is reflected on manual replacement pages chemo 28 (Part 2) and inject list 3 (Part 2).

Simultaneous Kidney-Pancreas Transplant Benefit

Effective retroactively to dates of service on or after July 1, 2005, inpatient providers may be reimbursed for simultaneous kidney-pancreas transplant services. To be eligible for reimbursement, providers must be authorized by the California Medical Assistance Commission (CMAC) to provide kidney-pancreas transplant services.

Providers must bill using the following national revenue and ICD-9 procedure codes:

- National revenue code 201 (intensive care, surgical) or 203 (intensive care, pediatric); and
- The primary ICD-9 procedure codes must be 52.80 (pancreatic transplant, not otherwise specified); and
- The secondary ICD-9 procedure code must be either 55.61 (renal auto-transplantation) or 55.69 (other kidney transplantation).

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Physician Services
Physician services for the kidney-pancreas transplant must be billed "By Report" with HCPCS procedure code S2065 (simultaneous pancreas kidney transplantation). A TAR is required, and the operative report must accompany the claim.

Organ Procurement
Inpatient providers whose contract excludes organ procurement may bill using their outpatient number and HCPCS procedure code S2055 (harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor) for kidney-pancreas procurement. A TAR is required, and an invoice from the relevant organ procurement organization must accompany the claim.

Exception to Claims Timeliness Requirement
As an exception to the standard six-month billing timeliness requirement, a three-month grace period from January 1, 2006 through March 30, 2006 is established to allow providers to submit claims for kidney-pancreas transplant procedures with dates of service on or after July 1, 2005. Claims submitted after this three-month grace period will be subject to the standard six-month timeliness requirement. See the *Claims Submission and Timeliness Overview* section of the Part 1 manual for more information about the six-month timeliness requirement.

Providers who billed and received payment for kidney-pancreas transplant but wish to request an adjustment based on the original claim must submit a *Claims Inquiry Form* (CIF). Refer to the *CIF Overview* section of the Part 1 manual for more information.

This information is reflected on manual replacement pages transplant 5, 7 and 12 (Part 2).

Primary Surgeon Rate Increases for CPT-4 Codes 58353 and 58563

Effective for dates of service on or after February 1, 2006, the primary surgeon rates have been increased for CPT-4 codes 58353 (endometrial ablation, thermal, without hysteroscopic guidance) and 58563 (hysteroscopy, surgical; with sampling [biopsy] of endometrium and/or polypectomy, with or without D & C with endometrial ablation).

CPT-4 Code	Primary Surgeon Rate Increase From:	Primary Surgeon Rate Increase To:
58353	$ 192.04	$ 1,067.62
58563	$ 400.29	$ 1,699.98

Current rates can be viewed on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "Medi-Cal Rates" under Provider Reference, then "View Medi-Cal Rates By Procedure Code."

Procrit, Epogen and Darbepoetin Policy Updates

Effective for dates of service on or after February 1, 2006, documentation requirements for the reimbursement of Procrit (HCPCS code X7030), Epogen (HCPCS code X6836) and Darbepoetin (HCPCS code X7493) are based on reaching specified target ranges of hematocrit and/or hemoglobin and are updated as follows:

Procrit (HCPCS code X7030)
Procrit reimbursement requires the following documentation:

- A hematocrit and/or hemoglobin level within the last three months.
- The amount of Procrit in units/kg administered to meet:
  - A hematocrit (Hct) and/or hemoglobin (Hgb) target range of 36 percent/12 g/dl with a threshold of 37.5 percent/12.5g/dl, or
  - Up to a target range of 39 percent/13g/dl with a threshold of 40.5 percent/13.5g/dl with documentation that a higher target ranger was required.

If the Hct and or Hgb threshold is exceeded, providers must include documentation with the claim that the dosage was reduced or held in response to exceeded thresholds. Documentation requirements of target/threshold ranges for Procrit are summarized on the *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form found at the end of the *Injections* section in the Part 2 manual.

Note: It is no longer a requirement that patients requiring doses higher than 150 units/kg, three times a week, have documentation of delayed or diminished response to Procrit or other treatment of anemia, including recent studies of iron stores, or that the dosage of anti-retroviral medication be at least 2,100 mg per week.

When billing Procrit for chronic kidney disease only, providers must bill using one of the following ICD-9 diagnosis codes:

- 585.1-585.5 (chronic renal failure, stages I, II, III, IV and V), or
- 585.9 (chronic kidney disease, unspecified) and 285.21 (anemia in end-stage renal disease)

In addition to current documentation requirements for all Procrit claims, providers must also include documentation that indicates a medical condition associated with anemia.

Please see **Procrit**, *page 4*

Procrit *(continued)*

Epogen (HCPCS code X6836)
Claims for Epogen must be billed in conjunction with ICD-9 diagnosis codes 285.21 and 585.6.

Darbepoetin (HCPCS code X7493)
The following ICD-9 diagnosis codes have been revised for the reimbursement of Darbepoetin:

- For anemia caused by chronic renal disease, 585.1 – 585.9
- For anemia due to treatment with chemotherapy agents for cancer, 285.29 (anemia of other chronic illness)

Note: Policy information for Darbepoetin has been moved from the *Chemotherapy* section to the *Injections* section of the Part 2 provider manual.

This updated information is reflected on manual replacement pages inject 13 thru 19 (Part 2) and the Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements form found at the end of the Injections section.

Activa Tremor Therapy Device Update

This article has been removed pending further review by the California Department of Health Services.

Medi-Cal Crossover Claim Reminder

Providers are reminded that when Medicare makes an adjustment on a previously paid Medicare claim, the resulting automatic crossover Medicare adjustment does not get processed by Medi-Cal. When a provider receives a Medicare adjustment, the Medicare claim for the adjusted amount must be submitted in hard copy form to Medi-Cal. Prior to submitting the new claim for the adjusted amount, the provider must void the original Medicare payment, or the adjusted claim will be denied with Remittance Advice Details (RAD) code **010: This service is a duplicate of a previously paid claim.**

To receive correct reimbursement from Medi-Cal for a previously reimbursed Medicare crossover claim, providers may file either a *Claims Inquiry Form* (CIF) or an appeal.

For information about completing a CIF, refer to the *CIF Special Billing Instructions* section in the appropriate Part 2 manual. For information about appeals, refer to the *Appeal Form Completion* section in the appropriate Part 2 manual.

This information is reflected on manual replacement page cif sp 7 (Part 2).

Contracted Inpatient Hospital Address Update

The California Department of Health Services (CDHS) selective hospital contracting list has been completely updated. Hospital contracts are continually changing so providers should review the information carefully. *This information is reflected on manual replacement pages contra 1 thru 15 (Part 2).*

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers now have the ability to submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through a third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF) that is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page, followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal then links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

New Sterilization Consent Form for Family PACT Providers Coming Soon

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of a California Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

The revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for the first quarter of 2006 are listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

January 23, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

March 20, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

For a map and directions to the DHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org** and click the appropriate date under "Orientation Sessions" and print out a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468.

If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228). Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

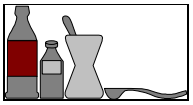
Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Please see **Family PACT**, *page 7*

Family PACT *(continued)*

Contact Information
For more information regarding the Family PACT Program, please call 1-877-FAMPACT or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.



DRUG USE REVIEW
***E**ducational **I**nformation*

Use of Inhaled Long Acting Beta2-Agonists in the Medi-Cal Fee-For-Service (FFS) Population

The Food and Drug Administration (FDA) has issued new warnings for all products containing long-acting beta$_2$-agonists (LABAs). The FDA has requested updates to product labels and a *Patient Medication Guide* given to patients receiving Serevent Diskus (salmeterol xinafoate), Foradil Aerolizer (formoterol fumarate) and Advair Diskus (salmeterol/fluticasone). The FDA issued the following warnings about the use of a LABA medicine for the treatment of asthma:

- Even though LABAs decrease the frequency of asthma episodes, LABAs may increase the chance of severe asthma episodes, and death when those episodes occur.
- LABAs should not be the first or only medicine used to treat asthma.
- LABAs should be added to the treatment plan after the use of low- or medium-dose corticosteroids has failed to control asthma symptoms, as recommended by the National Heart, Lung, and Blood Institute [NHLBI] *Guidelines for the Diagnosis and Treatment of Asthma*[1].
- Do not use LABA to treat sudden wheezing episodes or wheezing that is getting worse.

Providers should also be aware of the following:

- The warning does not apply to chronic obstructive pulmonary disease (COPD).
- The warning does not pertain to short-acting beta agonists.

For more information about label changes or how to obtain *Patient Medication Guides*, see the following FDA Web site pages:

- **www.fda.gov/cder/drug/advisory/LABA.htm**
- **www.fda.gov/cder/drug/infopage/LABA/default.htm**

The NHLBI *Guidelines for the Diagnosis and Management of Asthma*[1] recommends the following "Stepwise Approach for Managing Asthma":

Short-acting beta$_2$-agonist * → Add inhaled corticosteroid at low to medium dose → Add long-acting beta$_2$-agonist

* All asthma patients should have a bronchodilator (inhaled short-acting beta$_2$-agonist preferred) to use as needed for symptoms.

Medi-Cal conducted a retrospective study of recipients with a recorded diagnosis of asthma to determine if prescribers/patients are adhering to recommended treatment guidelines. Patients with a diagnosis of asthma (ICD-9 code 493) on a billed medical claim, and at least one pharmacy paid claim for a short-acting beta$_2$-agonist (albuterol) between January 1, 2004 and June 30, 2004, were included in the initial analysis. The claims for these recipients were analyzed for a one-year study period between July 1, 2004 and June 30, 2005 to determine if there was appropriate asthma step-therapy with respect to the addition of inhaled corticosteroids and LABA agents. There were a total of 21,369 asthma recipients identified who received only a short-acting beta$_2$-agonist agent during the six-month lead-in period.

During the 12-month study period:

- 12 percent of asthmatics began treatment with a LABA drug before trial/failure of monotherapy with an inhaled corticosteroid.
  - Of these beneficiaries, over 99 percent moved from Albuterol directly to Advair (salmeterol/fluticasone).

Please see **Beta$_2$-Agonists**, *page 8*

Beta$_2$-Agonists *(continued)*

For all non-Medicare Medi-Cal patients with a paid medical claim reporting a diagnosis of asthma in the same study period (N = 113,364), 26,912 recipients received at least one prescription for Advair. The study also yielded the following data:

- 15 percent of patients receiving Advair did not have a single paid claim in the same 12-month period for a short-acting beta$_2$-agonist agent as a quick reliever.
- 2 percent of patients receiving Advair had at least one occurrence of an inhaled corticosteroid filled on the same day as their Advair, with many patients showing up to 12 occurrences over the 12-month period.

Prescribers are reminded to refer to the NHLBI guidelines for the management of asthma patients. Pharmacists should carefully screen for duplication of asthma therapy and to consult patients taking LABA about the risk of severe asthma exacerbations.

Medi-Cal is monitoring the use and clinical outcomes of all long-acting beta$_2$-agonists.

To report any unexpected adverse events associated with these agents, contact the FDA MedWatch program at 1-800-FDA-1088; by FAX at 1-800-FDA-0178; by mail to MedWatch; Food and Drug Administration; HFD-410; 5600 Fishers Lane; Rockville, MD 20857-9787; or online at **www.fda.gov/medwatch/report.htm**.

[1] National Asthma Education and Prevention Program Expert Panel Report. *Guidelines for the Diagnosis and Management of Asthma–Update on Selected Topics*. Bethesda, MD: NIH/National Heart, Lung, and Blood Institute, (2002). (**www.nhlbi.nih.gov**).

Please refer to pages 36-28 and 29 in the Drug Use Review Manual.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 7 – Preferred Prior Authorization Drug List*.

Additions, January 1, 2006

Drug	Size and/or Strength
SOLIFENACIN SUCCINATE	
Tablets	**5 mg**
	10 mg
TROSPIUM CHLORIDE	
Tablets	**20 mg**

Change, effective November 22, 2005

Drug	Size and/or Strength
* LOPINAVIR AND RITONAVIR	
Capsules	133.3 mg – 33.3 mg
Oral solution	400 mg – 100 mg/5 cc
** Tablets	200 mg – 50mg
~~** Prior authorization always required.~~	

* Restricted to use as combination therapy in the treatment of Human Immunodeficiency Virus (HIV) infection.

Please see **Contract Drugs**, *page 9*

Contract Drugs *(continued)*

Changes, effective January 1, 2006

Drug	**Size and/or Strength**	
AMLODIPINE BESYLATE		
+ Tablets	2.5 mg	
	5 mg	
	10 mg	
(NDC labeler code 00069 [PFIZER INC.] only.)		
* FLUOXYMESTERONE		
Tablets	2 mg	
	5 mg	
	10 mg	
* **Restricted to the treatment of primary hypogonadism (congenital or acquired), hypogonadotropic hypogonadism (congenital or acquired), delayed puberty or metastatic mammary cancer in females.**		
* GALANTAMINE HYDROBROMIDE		
Tablets	4 mg	
	8 mg	
	12 mg	
Extended-release capsules	**8 mg**	
	16 mg	
	24 mg	
Solution, oral	4 mg/ml	
* Restricted to treatment of mild to moderate dementia of the Alzheimer's type.		
* METHYLTESTOSTERONE		
Tablets	5 mg	
	10 mg	
	25 mg	
* **Restricted to the treatment of primary hypogonadism (congenital or acquired), hypogonadotropic hypogonadism (congenital or acquired), delayed puberty or metastatic mammary cancer in females.**		
METRONIDAZOLE		
Oral tablets	250 mg	
	500 mg	
Injection	500 mg/100 cc	
Powder for injection	500 mg vial	
***** Topical gel	0.75 %	28.4 Gm
*** Prior authorization always required.**		
Vaginal gel	0.75 %	70 Gm
(NDC labeler code 00089 [3M] for vaginal gel only.)		

\+ Frequency of billing requirement

Please see **Contract Drugs**, *page 10*

Contract Drugs *(continued)*

Changes, effective January 1, 2006 (continued)

Drug	**Size and/or Strength**	
OFLOXACIN		
Ophthalmic solution	0.3 %	
Otic solution	0.3 %	5 cc
		10 cc

(NDC labeler code 63395 [DAIICHI PHARMACEUTICAL CORPORATION] for otic solution only.)

* Tablets	200 mg
	300 mg
	400 mg

* Restricted to use in the treatment of sexually transmitted diseases.

ONDANSETRON	
***** + Injection	2 mg/cc

* Restricted to a maximum of 32 mg per dispensing.

***** + Tablets	4 mg
	8 mg
* + Tablets, orally disintegrating	4 mg
	8 mg

* Restricted to a maximum of 12 tablets per dispensing.

(NDC labeler code 00173 [GLAXOSMITHKLINE] only.)

RAMIPRIL	
+ Capsules	1.25 mg
	2.5 mg
	5 mg
	10 mg

(NDC labeler code 61570 [MONARCH PHARMACEUTICAL CORPORATION] only.)

* TESTOSTERONE		
Injection in aqueous susp.	25 mg/cc	
	50 mg/cc	
	100 mg/cc	
Injection in oil	25 mg/cc	
	50 mg/cc	
	100 mg/cc	
	200 mg/cc	1 cc/vial
		10 cc/vial

* **Restricted to the treatment of primary hypogonadism (congenital or acquired), hypogonadotropic hypogonadism (congenital or acquired), delayed puberty or metastatic mammary cancer in females.**

\+ Frequency of billing requirement

Please see **Contract Drugs**, *page 11*

Contract Drugs *(continued)*

Changes, effective February 1, 2006

Drug	**Size and/or Strength**	
AZITHROMYCIN		
* Tablets	250 mg	
* Restricted to a maximum quantity per dispensing of six (6) tablets and a maximum of two (2) dispensings in any 30-day period.		
* Tablets	500 mg	
* Restricted to a maximum quantity per dispensing of three (3) tablets and a maximum of two (2) dispensings in any 30-day period.		
* Tablets	600 mg	
* Restricted to use in the prevention of infections caused by Mycobacterium organisms.		
+ Powder packet	1 Gm	
* Suspension	100 mg/5cc	15 cc
	200 mg/5cc	15 cc
		22.5 cc
* Restricted to use for individuals less than eight years old with otitis media infection.		
(NDC labeler code 00069 [PFIZER INC.] only for all dosage forms and strengths of azithromycin.)		
GLIMEPIRIDE		
+ Tablets	1 mg	
	2 mg	
	4 mg	
(NDC labeler code 00039 [AVENTIS PHARMACEUTICALS] only.)		

+ Frequency of billing requirement

Instructions for Manual Replacement Pages — Part 2

January 2006

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Remove and replace:	cardio 7/8 *
Remove:	chemo 23 thru 32
Insert:	chemo 23 thru 29
Remove and replace:	cif sp 7/8
Remove:	contra 1 thru 19
Insert:	contra 1 thru 15
Remove and replace:	hcfa sub 1/2 * hcpcs ii 1/2 inject 13 thru 34
Remove and replace at the end of the *Injections* section:	*Recombinant Human Erythropoietin (Rheupo) Documentation Requirements* form
Remove and replace:	inject list 3/4 preg ex hcf 11 thru 13 *
Remove:	radi dia 17 thru 25
Insert:	radi dia 17 thru 26 *(new)*
Remove and replace:	transplant 5 thru 8, 11/12

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-27
Insert:	36-27 thru 29 *(new)*

* Pages updated due to ongoing provider manual revisions.